COUNSELOR COMMUNIQUE

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New Year, New Outlook

By John Gary, CASAC, MSACCB President

By now you have celebrated the holiday season with family and friends and made your New Year's resolutions (some you will keep, some you will not). Try to keep the ones that will truly mean something to as you journey down life's winding road. Make time to do something that you have always wanted to do. Share your time with someone who is lonely, elderly or to a young person who needs a guiding hand. Lighten up. Will what is bothering you really matter in a few days or weeks?

As a counselor, you help individuals to change or make life-style changes. You help individuals gain insight into personal problems, to define goals and to plan action. We should be practicing what we tell our clients by taking care of ourselves. We know how busy our lives are and how important balance is.

As we know, substance abuse treatment is considered a cost effective approach to combating the problems associated with substance abuse. Despite the cost effectiveness of substance abuse treatment programs, a substantial gap exists between the number of people who need treatment and the number who receive treatment.

We keep hearing the phrase "do more with less." What does that really mean to us in this field? As budgets tighten and mental health costs increase, we are challenged to find ways to give the best treatment we possibly can. We must now focus on quality treatment not the quantity of treatment. We must adjust to the changing demands of our chosen field. Nothing remains the same in this changing world. We, as professionals, need to ensure we have the most up-to-date information and techniques. It is our professional responsibility to engage in continuous efforts to improve our profession and services to our clients. We have a new year and what we do with it...well, it is up to us.

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Eastern Region

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2004 Calendar of Events

January 15	Board of Directors Meeting
February 4	Application Deadline for June Written Exams
March 18	Board of Directors Meeting
TBA	Continued Quality Insurance Committee
April 16-17	CPM Orals
May 13	Board of Directors Meeting
June 12	IC&RC Written Exams for CSAPP, CASAC & CSAC
July 15	Board of Directors Meeting
August 4	Application Deadline for June Written Exams
September 10-11	CPM Orals
September 16	Board of Directors Meeting
November 18	Board of Directors Meeting
December 11	IC&RC Written Exams for CSAPP, CASAC & CSAC

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http://www.dmh.mo.gov/msaccb/

IC&RC Written and CPM Test Dates

CSAPP/CSAC/CASAC Exams

2004

Written Test: June 12, 2004
(Application Deadline: February 4, 2004)

December 11, 2004
(Application Deadline: August 4, 2004)

CPM:

April 16-17, 2004

Sept. 10-11, 2004

Newly Credentialed

RASAC I

Diane Maguire
Julia Blanco
Michael Caldwell
Dennise Cardin
Stuart Parr
M. Gail Suddarth
Jennifer Krohn-Siemer
Jacklyn Steinbeck
Anna Damalas
Mary Vaughn
Freda Theus
Dianna Sunderman
Tabatha Hyde
Shari Beck
Shawn Mullins
Tyrone Palm
Cheryl Ritzman
Jeanenne Dallas
Jennifer Wuertz
Brian Reese
Brenda Gahagan
Sally Scott Blackburn
Ervin Baty
Krishell Hadsell
Rudolph Willians
Thomas James Dosiak
Glenda Henderson
Rebecca Miles
Jon Cross
Willie Carter
Lacey Perry
Sadie Shipman
Kim Ballinger

RASAC II

Scott Myers
Samantha Olson
Ronald Swalley
Collee Neal
Douglas Quirmbach
Paula Davis
Sandra Dean
Fred Utley
Matthew Meier
Mark Watson
Stacey Foss
Tami Mayes
Curt Branson
Kevin Pearl
Jessica Frazier
Wm Kent Jewell

CSAC's/CASAC's by Reciprocity

Thornton Konkel
Susan Driver
Michael Tyner

CSAC's certified 9/03

Susan Epping
Irene Adams
Angie Carter
Clay Hyde
John White
John White
Elizabeth Pross
Youree White
Robert Keith

CASAC's

Craig Miner
Kelly Reed

Fall Election Results

Tom Gaudette, CASAC, was re-elected to represent the Northwestern region for the next three years.

He has served as the Northwestern Representative since October 1998 and has been certified since October 1990. He has a Bachelor of Arts degree in Addiction Studies.

Since 1987 Tom has gained experience in a variety of settings including state funded residential, hospital based treatment, SATOP, and correctional programs. He is currently the Program Manager for K.C.C.C. at W.R.D.C.C. in St. Joseph.

David A. Evans, CASAC, was elected to the Southwestern region for the next three years.

Dave has a Bachelor of Science degree from College of the Ozarks and a Master's of Science Degree in Guidance and Counseling from SMSU in Springfield, Missouri.

His work experience includes positions at the American College of Forensic Examiners: Assistant Director of Certification, Missouri Department of Corrections Chaplin. Sigma House: CRISP Mental Health Court and Drug Court and most currently DWI Court Administrator of the SATOP OMU CRISP DWI Court as well as providing consultation to Drug Courts in Springfield, Missouri

Dave is currently a LPCIT (Licensed Professional Counselor in Training) in the second year of supervision

Please join the Board of Directors in welcoming Dave to the Board and welcoming back Tom .

Naltrexone – The Implications for Treatment

By Percy Menzies, M. Pharm.

Development of Naltrexone

Naltrexone was developed in response to the need for a drug that would protect patients detoxified from opioids and continue their long-term relapse prevention treatment.

Patients do well, especially in inpatient or residential programs where they can be closely monitored and detoxified through a variety of protocols. The real challenge for treatment professionals is keeping the patients from relapsing to drug use when they are exposed to the familiar sights, sounds, smells and people associated with past drug use. These cues can precipitate intense symptoms similar to acute opioid withdrawal even when the patients have no drugs or alcohol in their system. This form of withdrawal is also called conditioned abstinence. Researchers were actively looking for a medication that was devoid of any euphoric activity, yet completely blocked the opioid receptors from being activated by opioids. The drug had to be an 'insurance' against accidental or impulsive use of opioids. Naltrexone met the criteria in every single respect.

Naltrexone was the first non-psychoactive or non-mood altering medication introduced for the treatment of addictions. Non-psychoactive medications are drugs that do not produce a 'high' or tolerance; are non-addicting, non-abusable, non-scheduled and have no street value. Naltrexone was approved by the FDA in 1984 for the treatment of opioid addiction.

What is Naltrexone

Naltrexone is a pure opioid antagonist that completely blocks the opiate receptors in the brain preventing endorphins or other endorphin like substances like heroin, morphine, etc., from binding to the opiate receptors and produce a 'high'. It creates a drug unavailable zone in the brain. In the absence of the 'high' the patients have less of an incentive to continue using opioids and thus become more involved in their recovery. A single dose of a 50 mg tablet protects the patients for up to 24 hours from the effects of up to 25 mg of pure heroin.

Endorphins are morphine-like substances produced by the body to mediate both pain and pleasure. Endorphins are essential for survival of the species. In response to the drive states like food, water, shelter, sex etc., endorphins are released and they bind to specific receptors called opiate receptors. The binding results in the feeling of pleasure or well-being. This pleasure is physiologic in nature vital for survival. There are drugs like morphine, heroin, codeine, etc., that mimic the endorphins causing an excessive or physiological stimulation of the endorphin system which can lead to addiction.

Naltrexone in Opioid Treatment

- Since Naltrexone is a pure antagonist, patients must be completely free from all opioid drugs for 4-6 days before starting Naltrexone.
- Initiate the Naltrexone is small doses (10 mg.) to minimize side effects and within 3-5 days stabilize them on the maintenance dose of 50 mg/day.
- Keep patients on Naltrexone for a minimum of six months and continue psychosocial counseling for about a year.
- Check liver enzymes every 4-6 weeks.
- Brief patients on the dangers of using opioids and attempts to override the effects of Naltrexone.

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Naltrexone and Alcoholism Treatment

It is hypothesized that the release of endorphins cause the high associated with drinking. By blocking the endorphins, the 'high' associated with drinking is lost and the incentive to take a second drink is lost.

Based on the work done at the University of Pennsylvania and Yale, the FDA in 1994 approved Naltrexone as the first anti-craving medication for the treatment of alcoholism. Again, Naltrexone is an adjunct to the psychosocial counseling. Patients generally take a 50 mg dose for about three months.

Success Factors for Using Naltrexone

Although Naltrexone on paper may appear to be a good medication, there are practical difficulties that have to be overcome in order to successfully utilize this medication. The biggest challenge is medication compliance. Since Naltrexone is a non-mood-altering medication, patients do not experience even a mild high. Patients can walk away from taking the medication and not experience any withdrawal effects. Often they will not take the drug on weekends, use opioids or alcohol and go back on it at the beginning of the week. The key success factors include:

- A thorough knowledge of the pharmacology of Naltrexone by each member of the treatment team. Excellent resources are available on the web and through the NIDA and NIAAA publications.
- Brief the patients on the unique pharmacology of Naltrexone and the reason they have been placed on it. Address all concerns related to taking a drug of which they know very little.
- Create a program where patients ingest the Naltrexone under supervision.
- Naltrexone should only be used in conjunction with individual and group counseling
- Work closely with a physician who will prescribe the medication and order the required blood test to check liver enzyme levels.
- Carefully select the patients who are likely to do well on a non-psychoactive medication. They include: patients with jobs, family, those with legal problems, patients experiencing strong baseline cravings for alcohol, and patients who have been abusing opioids for a short time, etc.

Resources:

- TIPS 28: Naltrexone and Alcoholism Treatment
- Research Monograph 150: Integrating Behavioral Therapies with Medications in the Treatment of Drug Dependence.

Both publications are available from SAMHSA at no charge by calling: 1800-729-6686.

Percy Menzies, M. Pharm. is the president of Assisted Recovery Centers of America, a drug and alcohol treatment program based in St. Louis. He can be reached at: 314-645-6840 or by email: percymenzies@arcamidwest.com.

Are You a SAP?

The Certification Board office maintains a listing of Substance Abuse Professionals (SAP's). We often receive calls for assessment or evaluation services for safety-sensitive personnel under U.S. Department of Transportation (DOT) rules. There are currently seven individuals who have notified this office of their eligibility to provide these services. If you wish to have your name added to the listing, please notify us by phone, mail, email or fax.

MSACCB
P.O. Box 1250 Jefferson City, MO 65102-1250
Phone: (573) 751-9211 Fax: (573) 522-2073
Email: msaccb@dmh.mo.gov http://www.dmh.mo.gov/msaccb/

Spring Training Institute 2004

Mark your calendar now!

The Missouri Department of Mental Health will present the Spring Training Institute from May 19-21, 2004 at Tan-Tar-A Resort and Conference Center at Osage Beach, Missouri. Additional information about presenters, workshops and registration will be mailed during February, 2004. Hear from experts about a wide range of topics including:

- Trauma
- Homelessness and Housing Options
- Vocational Support
- Medication Management
- Relapse Prevention
- Motivational Interviewing
- Compulsive Gambling
- Methadone Maintenance Therapy
- Transition from Prison to Community Issues
- Anger Management
- Co-Occurring Disorders
- Cultural Competency

Registration Fee: $125 per person/$50 daily fee

Emeritus Credential

Retired Emeritus Status

The Board may grant the classification, Retired Emeritus Status (RES) to certified substance abuse counselors who are fifty-five (55) years old, provided a minimum of ten (10) years of meritorious service and are retired from employment in the alcohol and other drug addiction field.

Certified counselors who desire the emeritus status must send a letter of request to the Board office indicating this request and the effective date of retirement. The Board staff will review all requests for the emeritus status and if the applicant meets the requirements the staff will approve the request and send a notice to the applicant. If an applicant does not meet the criteria they will be notified by the Board staff in writing.

No enrollment or renewal fees will be requested for the retired emeritus status.

The retired emeritus status individual may identify himself or herself as a Certified Substance Abuse Counselor Emeritus, shall continue to receive the Counselor newsletter and other Board communication.

The retired emeritus status individual will be ineligible for ICRC reciprocity and agrees to remain retired with no intention of returning to employment in the alcohol and other drug addiction field. If a retired emeritus status individual desires to regain an active credential the individual must write a letter of request to the board. They will need 15 hours of continuous education in the past six months and they will be charged $50.00 to reinstate their credential.

The Board may vote to grant this retired emeritus status to a retired counselor who has not made the request but meets the criteria for this classification.

Professional Liability Insurance

The Board office has received numerous calls regarding the availability of Professional Liability Insurance for substance abuse counselors.

The NPG Group is no longer offering insurance for IC&RC Member Boards.

If you are seeking information regarding Professional Liability Insurance contact:
The VanWagner Group at:

www.vanwagnergroup.com

Or

Healthcare Providers Service Organization at:

www.hpso.com

Both insurance carriers offer free information as well as quotations online or by phone.

22 Million Americans Suffer from Substance Abuse Dependence or Abuse

(SAMHSA News, Vol. XI, No. 3, 2003)
Reprinted from the newsletter of the Substance Abuse and Mental health Services Administration, U.S. Department of Health and Human Services

In 2002, an estimated 22 million Americans suffered from substance dependence or abuse due to drugs, alcohol, or both, according to the newest results of SAMHSA's Household Survey. There were 19.5 million Americans (8.3 percent of the population age 12 or older) who used illicit drugs currently, 54 million who participated in binge drinking in the previous 30 days, and 15.9 million who were heavy drinkers.

The report highlights that 7.7 million people (93.3 percent of the total population age 12 and older) needed treatment for a diagnosable drug problem and 18.6 million (7.9 percent of the population) needed treatment for a serious alcohol problem. Only 1.4 million received specialized substance abuse treatment for an illicit drug problem and 1.5 million received treatment for alcohol problems. More than 94 percent of people with substance use disorders who did not receive treatment did not believe they needed treatment.

There were 362,000 people who recognized they needed treatment for drug abuse. Of these, 88,000 tried but were unable to obtain treatment for drug abuse in 2002. There were 266,000 who tried, but could not obtain treatment for alcohol abuse.

"There is no other medical condition for which we would tolerate such huge numbers unable to obtain treatment they need," said U.S. Health and Human Services Secretary Tommy G. Thompson. "We need to enact President Bush's Access to Recovery Program to provide treatment to those who seek to recover from addiction and move on to a better life."

The new 2002 Household Survey has been renamed the National Survey on Drug Use and Health. The survey creates a new baseline with many improvements.

John Walters, White House Director of National Drug Control Policy, pointed out that "a denial gap of over 94 percent is intolerable. People need to understand the addictive nature of drugs and not presume that they are 'all right' when everyone around them knows better. Families and friends need to urge their loved ones to seek treatment when they experience the toll that addiction takes on loved ones and communities."

The 2002 survey found that marijuana is the most commonly used illicit drug, used by 14.6 million Americans. About one third, 4.8 million, used it on 20 or more days in the past month. There was a decline in the number of adolescents under age 18 initiating use of marijuana between 2000 and 2001, according to the 2002 survey. There were 1.7 million youthful new users in 2001, down from 2.1 million in 2000. The percentage of youth age 12 to 17 who had ever used marijuana declined slightly from 2001 to 2002, from 21.9 percent to 20.6 percent. Most adolescents age 12 to 17 reported that the last marijuana they used was obtained without paying, usually from friends.

"Prevention is the key to stopping another generation from abusing drugs and alcohol," said SAMHSA Administrator Charles G. Curie, MA, ACSW. "It is gratifying to see fewer adolescents under 18 are using marijuana. Now, we need to step up our prevention activities to drive the numbers down further."

The survey found that 30 percent of the population age 12 and older –use tobacco. Most of them smoke cigarettes. But, the number of new daily smokers decreased from 2.1 million per year in 1998 to 1.4 million in 2001. Among youth under age 18, the decline was from 1.1 million per year in each year between 1997 and 2000 to 757,000 in 2001. This is a decrease from about 3,000 new youth smokers per

day to 2,000 per day.

In 2002, 2 million persons currently used cocaine, 567,000 of whom used crack. Hallucinogens were used by 1.2 million people, including 676,000 who used Ecstasy. There were 166,000 current heroin users. Among adolescents age 12 to 17, inhalant use was higher than use of cocaine.

The second most popular category of drug use after marijuana is the non-medical use of prescription drugs. An estimated 6.2 million people, 2.6 percent of the population age 12 or older, were current users of prescription drugs taken non-medically. Of these, an estimated 4.4 million used narcotic pain relievers, 1.8 used anti-anxiety medications (also known as tranquilizers), 1.2 used stimulants, and 0.4 million used sedatives. The survey estimates that 1.9 million persons age 12 or older used OxyContin non-medically at least once in their lifetime.

Current illicit drug use is highest among young adults age 18 to 25, with more than 20 percent using drugs. Youth age 12 to 17 also are significant users, with 11.6 percent currently using illicit drugs. There were also 9.5 million full-time workers, 8.2 percent, who used illicit drugs in 2002. Of the 16.6 million illicit drug users age 18 or older in 2002, 12.4 million were employed either full or part time.

The 2002 survey found that 11 million people, 4.7 percent of the population age 12 or older, reported driving under the influence of an illicit drug during the past year. Those age 21 reported the highest rate of driving while drugged, 18 percent, but the rate was 10 percent or greater for each age from 17 to 25.

Other findings included:

Alcohol Use: Approximately 10.7 million people age 12 to 20 (28.8 percent of this age group) reported drinking alcohol in the month prior to the survey interview. Of these, 7.2 million were binge drinkers (19.3 Percent) and 2.3 million were heavy drinkers (6.2 percent). There were 33.5 million Americans who drove under the influence of alcohol at least once in the 12 months prior to the interview.

Treatment: Of those 3.5 million people age 12 or older who received some kind of treatment related to the use of alcohol or illicit drugs in the 12 months prior to the survey interview, 974,000 received treatment for marijuana, 796,000 for cocaine, 360,000 for non-medical use of narcotic pain relievers, 277,000 for heroin, and 2.2 million received treatment for alcohol.

Trends in Lifetime Use: Trends in lifetime use of substances were calculated from the 2002 survey based on reports of prior use. Use of pain relievers non-medically among those age 12 to 17 increased from 9.6 percent in 2001 to 11.2 percent in 2002, continuing an increasing trend from 1989 when only 1.2 percent had ever used pain relievers non-medically in their lifetime. Among young adults age 18 to 25, the rate of having used pain relievers non-medically increased from 19.4 percent in 2001 to 22.1 percent in 2002. This rate was 6.8 percent in 1992.

Youth Prevention-Related Measures: From 2001 to 2002, for teens age 12 to 17, the lifetime LSD rate is down from 3.3 percent of this population to 2.7 percent, the Ecstasy rate is unchanged from 3.2 percent to 3.3 percent, cocaine use is up from 2.3 percent of this population to 2.7 percent, and inhalant use is up from 9 percent in 2001 to 10.5 percent in 2002.

In 2002, the survey found over 83 percent of youth age 12 to 17 reported having seen or heard alcohol or drug prevention messages outside of school in the past year. Youth who had seen or heard these messages indicated a slightly lower rate of past-month use of an illicit drug (11.3 percent) than teens who had not seen or heard these types of messages (13.2 percent).

Serious Mental Illness: There are 4 million adults who have both a substance abuse disorder and serious mental illness. In 2002, there were an estimated 17.5 million adults age 18 or older with serious mental illness. This is 8.3 percent of all adults. Adults who used illicit drugs were more than twice as likely to

have serious mental illness as adults who did not use an illicit drug.

Among adults with serious mental illness in 2002, over 23 percent were dependent on or abused alcohol or illicit drugs. The rate among adults without serious mental illness was only 8.2 percent. Among adults with substance dependence or abuse, 20.4 percent had serious mental illness, compared with 7 percent among adults who were not dependent on or abusing alcohol or drugs.

Findings from the 2002 National Survey on Drug Use and Health are available online at www.DrugAbuseStatistics.samhsa.gov

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